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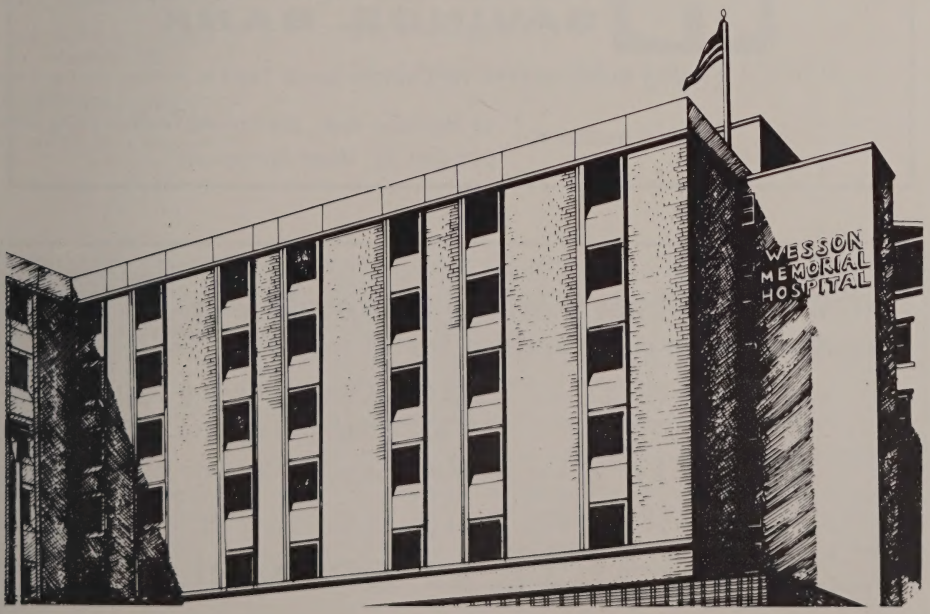

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THE HAMPDEN HIPPOCRAT is published monthly except for July and August.

The opinions expressed in this bulletin are those of the writers and do not reflect the official viewpoint of the Hampden District Medical Society unless so stated.

Communications pertaining to editorial content should be addressed to the Editor-in-Chief, 24 Salem Road, Longmeadow, Mass. 01106

Business communications should be addressed to the Business Manager, 91 School Street, Springfield, Mass. 01105

Communications pertaining to advertising should be addressed to Mrs. Arthur Willard, 62 Irvington Street, Springfield, Mass., 01108; Telephone: 733-5336.

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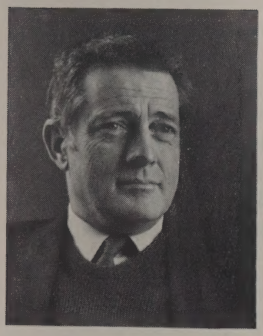

Your President's Page

Fellows:

At the last council meeting of the Massachusetts Medical Society Dr. Paul Moore stated unequivocally that the Society was still solvent. There is no question that this is better than the AMA. There is, however, a more difficult question to answer, does it serve its membership? Certainly there are those who would say, no, it does not. There are those who say it is a self interest group composed of Doctors from urban areas and it does not serve those in the periphery. There are those who say it is too conservative, too slow to act, and too disinterested. Personally, like everyone else I have my pet peeves about the Massachusetts Medical Society, but I have learned a lot about it over the past several years and I think it serves the physicians of the Commonwealth quite well. I want to talk about the things it does do.

Let's start by saying that the Massachusetts Medical Society basically produces the New England Journal of Medicine. This is considered to be the best Journal in the world. It is well known internationally for the articles and the scope of the material covered. The Massachusetts Medical Society also founded Postgraduate Medical Institute and carried on with it for many years by partially subsidizing its services. While this organization was not thought as highly of within the state, other areas felt it was one of the best Postgraduate units available. It is probably going to be supplemented by Continuing Medical Education which will be required of all physicians over the next several years, including, relicensure. The continuing medical education unit will make available to all physicians in their own area approved local programs and credit them and the physician for the attendance. The Massachusetts Medical Society supports the Countway Library which is considered to be one of the finest in the country. It is difficult for people in our district to use this Boston Library and therefore we have raised the question of whether or not the society would be willing in the future to support the Academy of Medicine Library in Springfield. Further decisions will be forthcoming on that. The Medical Society does provide its membership with group type Blue Cross-Blue Shield as well as certain types of disability income group policies, not directly as a Medical Society but through those agencies that it works with. The society in conjunction with the specialties' societies has produced the Massachusetts relative value fee schedule which has been in operation, after being accepted, over a period of many years. It is patterned after the California unit value system and it has been of real value to the membership. The society set up the Commonwealth Institute of Medicine a few years ago in the hopes that it might become a useful coordinator of material for both the incipient PSRO's. It also developed, through the Commonwealth Institute of Medicine, a mechanism by which the Welfare Department for the state was able to review, via the Champ program, hospital care for the Medicaid patients. While there is

controversy over the net worth of this program there is no question that it has had more physician input and less stringent regulations than would have been present if this program were developed under full welfare auspices. More recently the Massachusetts Medical Society has been very deeply involved in the whole crisis of Malpractice, worked carefully with the legislature of the state and was instrumental in the development of the legislation which allowed occurrence type malpractice insurance to continue to be available to the membership through the JUA. It plans to continue its coverage of the problem and continue its input into the problem. It has, in the last year, through its public relations department been the sponsor of an anti-self pollution campaign which has been praised throughout the state and has been utilized in other areas than the state of Massachusetts because of its impact. It does in fact have on its executive committee input from every one of the district medical societies, and while its officers are basically elected from the executive committee there is input from the membership even in this area.

Therefore examining this in total I would say that we do in fact have a state Medical Society that is responsive and has been active in trying to care for the broad self interest areas of the physicians of Massachusetts. It has anticipated some of our needs and gone forward to try and solve these before they became excessively critical. I feel that as a physician in Massachusetts that the benefits of belonging well outweigh the detriments of not belonging.

See you at the November meeting!

Gardner Cox II, M. D.

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HIGHLIGHTS OF THE EXECUTIVE COMMITTEE MEETING OCTOBER 21, 1975

The Executive Committee convened at 7:30 P.M. on Tuesday, October 21, 1975 in the Conference Room of the Hampden District Medical Society.

Present were Drs. Moore, Kelley, Cox, Walthall, Trachtenberg, Lynn, Bloom, Teale and Mrs. Purdy. Absent were Drs. Stoler, Stoddard, Smith and Kraus. The minutes of the September meeting were read and accepted as read.

Dr. Magill, Secretary of the Springfield Academy of Medicine, was present seeking financial aid to the Academy. Dr. Moore, Finance Chairman for the Massachusetts Medical Society, discussed the resolution presented to the Finance Committee and then to the Council where it was defeated. (The resolution is attached to these minutes.) Upon motion duly made and seconded it was voted to present this crisis to the full membership of the Hampden District Medical Society at the November 25, 1975 meeting and then send it on to the Massachusetts Medical Society again to be presented to the Council again.

CORRESPONDENCE

1. Dr. Platt wrote telling the committee about the new tax package of the Commonwealth of Massachusetts and its effect on the self employed persons who are saving income under the Keogh Plan. He asked that the Hampden District Medical Society write the legislators about this unfair legislation. Upon motion duly made and seconded it was voted to write a letter, contact the legislative councilor and consult John Noonan of Massachusetts Medical Society about this tax package.

2. A letter from Dr. Ayres asking for a physician representative to a committee, to plan for the coordinated delivery of comprehensive human services to the residents of Springfield was read.

3. The Congregation Sons of Zion wrote thanking the Hampden District Medical Society for their "blessing" to the Mini Health Screening program. At the end of the screening report it says "The above screening tests are done by nurse volunteers and certified Laboratory technicians with the approval of the Hampden District Medical and with physician supervision. For further information please see your own doctor. He is an irreplaceable friend."

4. Northeastern University sent information on "Physician Assistants." Mrs. Chroback, Assistant to the Director, asked to meet with interested persons at the WMHPC offices on October 22, 1975. Mrs. Purdy will attend this meeting and report back to this committee.

5. Several applications had come through from the WMHPC for changes in nursing homes, health clinics, hospitals, etc. These had been reviewed and upon motion duly made and seconded it was voted to send letters to the council expressing no opposition to the proposals.

Another request was made from the WMHPC asking for comments on the report of the Environmental Health and Planning document. The committee suggested that a letter be written stating that the report is accepted as informational and the Hampden District Medical Society is interested in the follow up.

6. Mrs. Purdy gave a report of the hearing held at City Hall identifying the health problems confronting residents of Springfield. The committee asked her to attend the hearings to be held on October 23rd.

7. Dr. Gephart wrote an answer to the letter written him on a "spokesman" for each district and the committee for redistricting. Answers had been received from the other western district Presidents. Dr. Purinton, Secretary of Franklin, indicated that each district should be on the redistricting committee. However, the Executive committee suggested that the Franklin District appoint a person to represent western Massachusetts and then report back to the other three districts.

8. Two letters from Attorney Flanagan were read and the committee advised that these be sent to the Medico-Legal Committee.

9. Mr. Dennis Casey, Assistant Administrator of the Providence Hospital wrote that the Arbitration Plan had been reviewed by them and they have forwarded it to their insurance company.

10. The AMA sent a notice that the local medical societies should try to review by-laws with the AMA by-laws to modify delinquency provisions to include assessments, as well as dues. This will be sent to Dr. Memery, Chairman of the By-Laws Committee.

OLD BUSINESS

Dr. Cox gave a report of the suggested speakers for the November meeting. Dr. LaMaitre of the Council of Medical Staffs will speak on Blue Shield, Mr. Meyrick will speak about controlled substances and Mr. Woolrich from the WMHPC will speak about PL 93-641.

Dr. Lynn gave an excellent report of the meeting the Mediation Committee had with Mr. Meyrick of the DEA. After listening to him the committee agreed that this problem of indicted physicians should be studied further and the society attorney should be contacted for advice and counsel.

NEW BUSINESS

A resolution was read which will be sent to MMS which will ask to have the October, 1976 Council meeting be held in Springfield.

Dr. Cox gave some brief reports of some of the information given at the President's conference held in Framingham in September. The committee was very much opposed to allowing hospital staff to sit in on Executive Committee meetings, as suggested by Dr. Alfano. The question of the state society doing the dues billing was also opposed as Hampden has the district office.

Dr. Stevens suggested that HDMS should become the Center for collecting the Continuing Education points of their members. The Executive Committee approved this suggestion but the mechanics have to be worked out. Dr. Bloom will report this to the membership at the November meeting.

Mrs. Purdy gave a report on the use of bulk mailing for the membership and commented on the savings.

A report was given of the meeting of the Scholarship Committee. Five awards were given from the fund that the HDMS has and six were given from the funds that are at MMS. Of the last fund four were medical students, one a D.O. and one a pharmaceutical student.

The Dr. Millman Memorial Fund is to become a loan program to students. Dr. Coen, Chairman, is having this set up legally.

Mrs. Purdy reported about a meeting she had with Mr. Scofield of the yellow page listing of the telephone book. The specialties are to be listed but the HDMS disapproved of this listing in its present form.

A report was given about the Health Fair and its progress.

The merger of the Medical Center of Western Massachusetts and the Wesson Memorial Hospital was discussed.

The meeting was adjourned at 9:30 P.M.

Submitted by the Assistant Secretary
William W. Walthall, M.D.

Hampden District Medical Society

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Editorial Comment:

Hospital Merger

The proposed hospital merger is a reflection of the time. The Boards of Trustees of the Medical Center of Western Massachusetts and Wesson Memorial Hospital strongly believe that corporate merger will provide distinct benefits to to the community in terms of coordinated services at lower cost to the consumer. This can be achieved by combining administrations and medical staffs in cooperative future planning for expansion and equipment acquisition. This move is strongly supported by the 12 major financial institutions of the area who provide the major share of capital support, particularly when separate hospital plans presently indicate a sum of 40 to 50 million dollar cost to the community.

Needless to say, the Federal Government is increasingly involved in controlling capital expansion in the Health Industry. Precipitant to the present issue perhaps in the Betatron High Energy Unit sought by both hospitals. With the Health Planning Council and State Agencies tightly controlling major acquisitions and expansion joint planning is essential for survival.

The November 25 vote by the hospitals' corporators will indicate each institution's willingness to press forward to meet the challenge of the future.

The Assistant Editor

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Thanksgiving 1975

According to what we read in the papers these days, and in the magazines, and what we see in the television documentaries, and overhear in department stores, bus stations, theatre lobbies, cocktail parties and bars, the sick person in modern American society is in a bad way. Doctors don't make house calls any more; if you go to their offices they insist on a whole host of laboratory tests; hospitals are fiendishly expensive; and furthermore every one in the health care field utterly ignores the principles laid down by Hippocrates, Maimonides, Paré, Sydenham, Osler and all their disciples, and worships solely at the feet of Mammon.

The situation has gone to hell in a hand-basket. There is a crisis in medical care. Congress, although completely confused, must step in. The bureaucrats, although in their infinite wisdom and perspicacity have clobbered everything from cyclamates to swordfish, insist they have solutions to problems only they have created.

When the various individuals and organizations—social, scientific and political get involved in the health care morass the cerebral smog thickens and coagulates. Legislators are off and running, and stopping and starting, and crawling and holding hearings. Ten years ago, after signing the bill establishing Medicare, President Johnson trumpeted, "This is only the beginning." Now, with governmental budgets at all levels wavering like willows in the wind, President Ford is naturally unwilling to endorse the idea of spending several billion dollars on a program of health care that currently has a paucity of enthusiastic advocates. The public and the medical profession find themselves perched precariously on the horns of a colossal dither.

Under these parlous circumstances what is there for the sick person or his family to be thankful for in this melancholy Bicentennial year of 1975? Well now, let's think this thing through. We don't need to go back 200 years to discover improvements in our medical status. We don't need to go back 50 years, when, in 1926 in Springfield there were reported 208 cases of tuberculosis with 89 deaths from that disease, and among the children there were 49 cases of diphtheria with 5 deaths, 41 cases of poliomyelitis with 3 deaths, and 322 cases of whooping cough with 10 deaths. But who cares what happened 50 years ago?

What about 40 years ago? There was no modern anesthesia then, no blood banks, and no antibiotics despite the recent comment of a columnist in the *Springfield Daily News* that "By 1928, penicillin had been invented."

Thirty years ago there was no chemotherapy for cancer or tuberculosis, no radioactive isotopes, no intensive care units, and the only transplantable organ was the skin. Since then, and there is nothing to be gained by separating the events into decades, the entire field of genetics has burgeoned, much has been learned about the causes of congenital defects, the artificial kidney and renal transplants have revolutionized urology, organ scans have become a potent diagnostic tool, tranquilizers and mood elevators have had a profound effect on psychotherapy, and the specialized techniques of cardiovascular surgery have flourished.

Ernest A. Byron, Jr.

• • • • • •

SPRINGFIELD

Those who maintain that many of the advances made in recent years have been largely funded by government grants have a perfectly valid point. But it is the people in the medical and para-medical professions—chemists, physicists, biologists, technicians, nurses and physicians—who bring these benefits to the bedside of the sick, the injured, the premature and the aged, who have brought about these results that the public takes for granted and gripes about the expense.

If there are a dozen of the family gathered around the turkey and fixin's this Thanksgiving, give thought to the realization that if you were living under the circumstances prevalent a generation ago three or four of you might not be there.

Howard N. Simpson

Landen-True

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* **Indications:** *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

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Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

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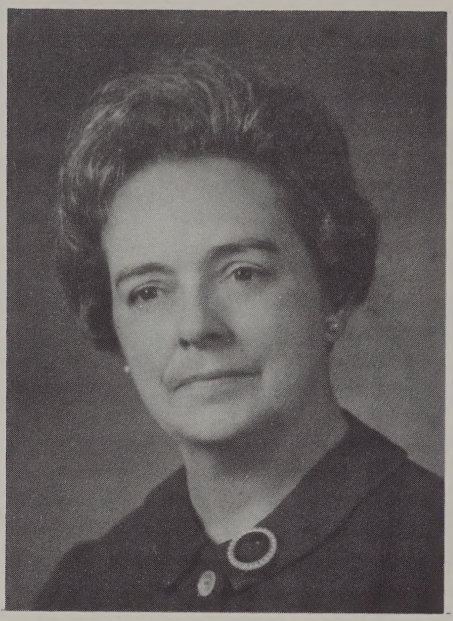

Vivian M. Purdy, R.N.

Many of the readers of the *HIPPOCRAT* may not have noticed The Springfield Daily News article of September 11, 1975. Our gal Viv has been honored and will be listed in the 1975-1976 edition of Marquis "Who's Who of American Women." Too often we have taken Viv for granted and have not taken the time to say "thank you" to this woman who has readily and agreeably given of herself to make our Society go. As a past officer and as Editor-in-chief I have known Viv well for the past 5 years and less well for the 5 years prior to these. She had introduced me to the Board of Censors and has made *all* my tasks associated with the Hampden District Medical Society easier and more pleasurable. So from me Viv—Thanks. Thanks for a job well done guiding the officers and the Society since 1961. Fourteen years of devotion have not gone unnoticed by many, even though it may seem to have gone unrewarded. We all love you and pray you stay with us for another 14.

What follows is a 'swiped' copy of what was given as biographical data for use in the Who's Who. It is appropriate to include these comments in this issue about the females and the Auxiliary. Viv is an aid to the ladies (distaff side) of our Society, as well.

W.E.S.

Vivian M. Purdy, R.N., Executive Secretary, Hampden District Medical Society (since 1961)
Born: Ossining, New York
Education: Ossining High School; Graduate Mt. Sinai Hospital School of Nursing; Association Management courses, Chamber of Commerce at Syracuse University
Widow of: Ira J. Purdy
Two daughters: Kim Graham of Seattle, Washington; Pam Scott of Charlton, Massachusetts; and Six grandchildren
Past activities from 1961 to 1975:

Treasurer of Women's Division of the Springfield Chamber of Commerce.

President of the Visiting Nurse Association of Springfield.

Vice-President of the Springfield Memorial Society.

Secretary of Western Massachusetts Public Health Association.

Associate Member of the American Medical Association.

Member of American Association of Medical Society Executives and Board of Editors of its publication, "The Executive."

Member of the Zonta Club of Springfield.

Member of Springfield Business and Professional Women's Club.

Member of Hampden District Medical Assistants.

Member of New England Public Health Association.

Member of Valley Press Club.

Member of the Massachusetts Heart Association (also Board of Directors).

Member of Advisory Committee of Easter Seal Society.

Member of Human Development Committee of Chamber of Commerce of Springfield.

President of Women's Division of Chamber of Commerce.

Member of Board of Directors, Chamber of Commerce.

Member of Convention Bureau, Chamber of Commerce.

1975—Who's Who in American Women
1975—Newly elected President of the Western Mass. Public Health Association
1975—Member Association—Legislative Committee—Chamber of Commerce
1975—Board member of the Convention Bureau, Springfield
1975-76—Coordinator and Corresponding Secretary for "Health Fair '76"

Volunteer Work (previous to 1960):

Parent Teachers Association, and Secretary to Parent Teachers Council.

Springfield Symphony Drive.

Captain, United Fund, Ward 7, Precinct 8.

Captain, Polio Drive, Ward 7, Precinct 8.

Salvation Army Drive, Captain.

President, Woman's Guild, St. Barnabas Church.

Chatham Revisited—A Factual Report

The Chatham Bars Inn, on the Cape, was the site of the 1975 Blue Shield Professional Relations Conference. The dates were October 3, 4 and 5. Ideal early Fall Cape weather prevailed, providing a serene but stimulating atmosphere to listen, to think and to propose. Thinktank mentality existed until the cocktail hours. On Saturday, the 4th, the theme of the presentation was "National Health Insurance" and on Sunday the 5th, "Professional Liability."

The National Health Insurance session was chaired by the Honorable Daniel J. Foley (the Massachusetts Senate's Chairperson of its Insurance Committee), who did an excellent job. It was a pleasure to watch this particular legislator work and think; we physicians are lucky that he is in this position. He is aware of our problems and those of the state and is attempting to solve these problems and resolve the differences.

Mr. Melvin Glasser—Director of the Social Security Department of the United Auto Workers, was the first speaker. He presented the official views as held by his organization—which are for most incorporated in our Senator Edward Kennedy's bill. Mr. Glasser indicated that the problems of health care delivery facing the nation, call for solutions which require long periods of deliberation and evaluation. The Union is not anxious to support a poorly thought-out bill. The Union's 5 million are the largest single group contributing to a health care plan; last year 1.3 billion dollars were envolved. He further stated that American Medicine faces a dilemma; to wit—providing access to the system as a right for all and recognizing and utilizing the superiority of the medical practice in that system. Americans spend a higher percentage of their Gross National Product on health than do any other world nationals.

Mr. Glasser supported this Editor's opinion that the practice of medicine is good but that the delivery of health care was bad. What is needed, according to Mr. Glasser, was and is better and proper organization, equitable financing and methods of delivery. Statistics, which have been used by Senator Kennedy, were quoted to support his arguments. One of which was that 42 million Americans, under 65 years of age, are without third party health insurance coverage.

(Cont. page 17)

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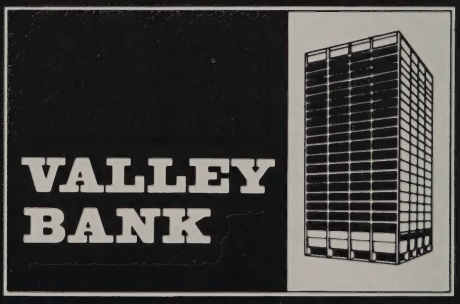

*Higher insurance levels may be established. Ask for details.

Mr. Glasser then posed five questions as statements and gave his ideas of their answers. #1. There is **no national Health Policy:** the Union's Bill would resolve this. #2. The **costs of health care are uncontrolled** and running wild: this cost is now 7.7% of the GNP and is rising 2X faster than the cost of living index—by the end of September '75. It was 58% ahead of the index, the Auto worker now gives up one month's salary to get coverage and if current trends are maintained in 4 years it will take two months work.—The controls of the Union's bill would slow and stop this. #3 There is a **lack of access** to all into the delivery system: the inability to enter is primarily financial, with a shortage of physicians in the poor neighborhoods, there is no transportation to reach the suburban physicians, large scale preventive medicine is not practiced in this country, and as an example of poor planning he sited the fact that there was an excess of acute care beds and an insufficiency of chronic care beds—These oversights or undersights are considered in the Union's bill. #4. There is a **fragmented organization of service:** Only 1/3 of the country's M.D.'s are in primary care and this is less in absolute numbers than 20 years ago, population migrations resulted in dislocations of old delivery patterns, physician specialization has made the patients seek many men for a single problem which often is not tied together with other illnesses because the family practitioner is not there to do it—The Union's bill will suggest restructuring physicians proportions and locations. #5 There are **inadequacies in the quality of medical care** available to the population: He indicates that one half of all the surgery is unnecessary, that there is a death loss per annum of 130,000 people from adverse drug reactions of which 70-80% are predictable and therefore preventable. Over 50% of the country's hospitals may be delivering less than optimal care because they fail state safety regulations, 30% of all X-rays taken must be repeated because of poor technique and quality control and 190,000 American die annually of and with treatable cancer.

Mr. Glasser then summarized his remarks so far and then indicated that the Union's bill was the result of 30 years of effort to devise the proper solution and interrelationship of these 5 problems. The Union now feels that in addition to financing adequately, 8 items must be present in any N.H.I. bill to make it acceptable: 1) a single universal program covering all, so that all risks are spread to all people; 2) no deterrents or provisos; 3) simple and equitable public financing; 4) built in incentives to reorganize system to encourage new programs of delivery; 5) screening of quality; 6) incentives to overcome shortages in all areas and specialties, to improve distribution; 7) effective consumer participation, even today 40% of the money involved in health care delivery is Federal; 8) create an agency to take responsibility to locate resources in proper places and to fill shortages and gaps in the system. (Ed. note: The words non-system are no longer current usage.)

Mr. Glasser then went on to outline the 5 most prominent bills under study by the Congress and its study committees; there are 36 submitted bills to date. #1 The AMA bill which utilizes the principle of mandated coverage by employer and keeps out of tax revenues. #2 The Health Industry Plan which seems complex and gives the state insurance commissioner control. #3 Current Administration Plan, there seems to really be none. #4 Catastrophic coverage with a $10,000 deductible does not meet his 8 requirements and he feels it will be a catastrophie in itself. #5 Kennedy Bill (This was his first direct use of the Senator's name) answers all his requirements, has quality and cost control and has 22 provisions for encouraging evaluation and change in the delivery system. He claims that all the programs will cost the same eventually and inflation makes prediction of costs very hazardous.

(Cont. page 18)

In a survey conducted by the Union to determine the Public's attitude to National Health Insurance the opinions returned were as follows:

Mass	USA	
xx	13%	Keep system as is
xx	23%	Catastrophic and Blues
45%	35%	Kennedy-Union plan
32%	22%	Complete governmental take over—National Health Service
xx	7%	no opinion

As to the progress of legislation thru the Congress, he feels that nothing will reach the floor this year. His 7 years of union experience suggest that passage will occur in 1976, in the next Congress. The Union is willing to compromise and it realizes that slow deliberate action and thought is best.
(Editorial Note:) At the conclusion of Mr. Glasser's presentation, we all were duly impressed with his ability to speak and present the facts as disclosed and interpreted in his own manner. He is a suave, intelligent and clever man; I would suggest that the AMA hire him from the Union to plead our case.)

After the Coffee Break Dr. Ronald M. Klar spoke.

Dr. Ronald M. Klar, the Executive Secretary to the Health Insurance Benefits Advisory Committee of the Federal Department of Health, Education and Welfare presented the Government's views in a paper entitled "Development of a Health Care System." His stated goal was to reveal what is current in Washington thinking on National Health Insurance. (Ed's Note: It should be noted that no talk was directed to a National Health Service Program or Service—all the speakers indicated that **the action** lies with and for an Insurance scheme only.) In the Federal approach and presumably the administration's concepts, National Health Insurance must take into account the interrelated problems of housing, food and education before nationwide good health is achieved. Preventive medicine can not be practiced in a vacuum wherein the patient is not adequately housed and fed. Financing and administration are the major stumbling blocks to any plan which may be introduced, the Congress is not anxious to add to the inflationary rate and therefore fortunately breathing time has developed in the congressional committees and the tide towards NHI is a slack ebb and not full flow. The administration of President Ford espouses to the C.H.I.P. plan but the Office of Management and Budget is scrutinizing all plans for flaws and hidden time bombs of cost.

Dr. Klar suggested six principles for a National Health Policy. #1 Universal and voluntary participation: all people have the freedom to choose from a variety of plans suitable to themselves and their own circumstances. #2 The Benefits must be uniform and Comprehensive: to the public servants and all, balance of options must be made thru adequate substitution roles, there must be continuity of coverage and there must be catastrophic coverage. #3 Plan must build on strength of private insurance already in effect, development must be by growth and evolution. #4 Funding should be basically private using public funds only when necessary. In 1974, 62% of citizens were covered by some form of a private plan. There is no need to shift to public funds for these. #5 A partnership between public and private sectors needs to be reached with the Federal government balancing and monitoring the cash flow. This could be achieved at the state level, by state governments in most instances. #6 The control of the structure of the delivery system should be through incentives. The M.D.'s must be kept as free agents and the "no have" areas made rewarding to the practioner. The Public Health Systems also should participate more in the delivery of health care.

(Cont. page 19)

The P.S.R.O.'s are not the last word or the only way to checking quality and containing costs. Federal funds should be used to "encourage" new directions of growth and exploration to improve the delivery system. National Health Insurance will not be activated for at least two years according to Dr. Klar; he expects the second session of the next new Congress to pass the bill. As of now there are too many, more important problems which require large federal spending and/or require fiscal tightreigns to prevent an acceleration of the inflationary spiral. The politics of an election year and the settling in of the new Congress persons always acts as a brake to advancing legislation. (Thus this is all the lead time we have left to get our ideas across to our legislators—Ed.) After his summary, Dr. Klar concluded with the remark that the Department of H.E. & W wants to work with the American Physician, so that an equitable National Health Insurance program can be enacted for the good of the entire country.

Malcolm G. Taylor, Ph.D., L.L.D., Professor of Public Policy at York University—Ontario, Canada, gave an erudite presentation of the history of the development of the National Health plans in force in our northern neighbor. He further outlined the similarities and the differences in the two countries' health care delivery systems and how their form of democratic government differed from ours in control and division of powers. A very telling point and one which should be adapted "south of the border" is that every major campaign promise must be addressed by the legislators some time during their term of office. If this is not done, there is cause to call for a vote of confidence. The ten providences spent about $3 billion on hospital care and $1.4 billion on medical care in 1974, this represented 6.8% of their GNP. There are relatively more physicians in Canada than here; the ratio is 1 physician to each 600 population. Dr. Taylor's presentation was timely and provided depth and perspective to our own problems.

Senator Foley then chaired a very lively question and answer period. The Saturday session then was adjourned for an on-beach clambake.

Sunday's session began at 9:30 AM and was chaired by the Honorable Raymond M. LaFontaine the Massachusetts House Chairperson of the Legislature's Insurance Committee.

Here again it was pleasurable to watch one of Massachusetts' own at work and then realizing that this able mind was working for us and the Commonwealth. The format was different in that a panel discussion had been organized in which three speakers gave their views on the major topic and then the members in the audience were able to question the panelists and the Chairman Mr. LaFontaine. The topic was "Professional Liability: Past, Present and Future."

(Cont. page 20)

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Neil L. Chayet, Esq. who specializes in Malpractice litigation spoke first. He outlined the legal procedural steps that must be taken to initiate a malpractice suit and what does and does not induce a lawyer to take on a client's complaint. Mr. Chayet again reiterated the known fact that most suites develop because the physician does not adequately communicate with his patient and gives the patient a sense of abandonment and/or inferiority. He suggested that the Law has lost reality with the current situation and it must be brought up to 1975 practice standards and codes. He has reviewed all the current malpractice and professional liability statutes, especially those recently enacted and he believes the Foley-LaFontaine bill, now the law in Massachusetts, to be the best of all. Amendments seem necessary and suggested that catastrophic coverage be included, that availability of insurance be tied to P.S.R.O. reviews, that caps or ceilings to awards may be necessary (altho illegal ?) and that more efforts be directed to preventing cases from coming to trial or court.* He acknowledges a crisis still exists and with the loss of St. Paul, to half of the Massachusetts physicians, further legislation is imperative **this** year.

Russell B. Roth, M.D., Past President of the AMA spoke next. He spent about ten minutes shooting down some of the material presented yesterday by Mr. Glasser. This was done in a neat and orderly fashion, without malice and he turned the cupidity properly. He restated that only 17 cents of the premium dollar was returned to the patient. Dr. Roth then presented the views of the physician (within organized medicine) as to the defects of the current professional liability system. #1 Regardless of what the insurance premiums become, if physicians are to continue to practice, the patient will pay for these premiums—thus driving fees and medical costs further upward. (Ed's note: No insurance actuary can determine a premium without knowing how many cases his company will be forced to defend in a given year or how much the awards may be. The rates of cases and the amount of top judgments have not peaked and do not seem near to peaking). #2 Defensive medicine adds uncountable dollars to the patient's bill without value or benefit. #3 Part time physicians have ceased to practice thereby adding to physician maldistribution and reducing availability. #4 Teaching programs are suffering because the preceptor is not willing to take the risk of letting a resident do the work or treat the case. #5 Dr. Roth suggested that perhaps all physicians should carry no insurance and explain to their patients that the taking of medicine or the submission to surgery carries certain risks which the patient must assume not the physicians. (The Editor trusts this was facetious.) #6 When the insurance companies withdrew from the several states, they took with them their actuarial experience and any company put together by a medical society will have rough sledding.

(Cont. on page 21)

*(Dr. Boss's arbitration plan is excellent for this purpose – Editor.)

Dr. Malcolm M. Taylor of York University, Ontario, next spoke and again ably presented the Canadian experiences and contrasted them to the American problems. Canadian patients' interests in suing their doctors is increasing as is the number of cases coming to court. The average settlement is $13,396. The finances are different than ours with 30,000 physicians paying about $200 per year. The CMPA is the agency for handling professional liability and there is no formal contract between physician and the CMPA. This agency does approve of out of court settlements but many cases do proceed to court and the highest settlement is set at $175,000 and all cases are heard before a judge without a jury. The lack of patient-physician communication is the chief cause of litigation in Canada, as well. The contingency fee system does not exist in Canada.

The question and answer period which followed was not as lively or spirited as that on Saturday. The questions where more searching and factual answers were returned.

Mr. John Larkin Thompson, the President of Blue Shield of Massachusetts, Inc., was the final speaker and his closing remarks were "instructional." He indicated that it was Blue Shield's task to present all the views on the problems discussed and then for all men and women to reach their separate conclusions; he expected no unanimity of opinion. The session was adjourned and the apecialty of the Chatham Bars Inn Breakfast Bar became available to our parched throats—namely extravagantly, good Bloody Mary(s).

Again the Editor wishes to commend Blue Shield and its employees who strove (successfully) to please the mind and body. On the drive home, the editor was struck with the need for more of the same, i.e. the Thinktank Atmosphere in which all persons interested in improving the delivery of health care get together in small cadres, about the state and actively participate in a give and take morning. This would allow all sides to see the problems and attitudes of his fellow cadrites and then, together, a forward looking program could be developed. For as long as each provider or consumer sits unto him-or herself and does not interact, the delivery of health care can not improve, except in a negative way. Improper ideas will enter and not be refuted. The Editor would therefore suggest that the Third Party Payors and the New Health Planning agencies act as the catalyst to plan for such thinktank sessions around the state and that the results from these "bullsessions" (?) be passed upward to state and regional representatives of the sponsors and in turn their pooled data and ideas be transmitted to the legislature and the executive branches of our government. "Truly, if and when the populace wishes to be heard, it must speak strongly and wisely to its elected representatives; otherwise the blame for no or poor legislation lies within itself."

W. E. Stevens, M.D. F.A.C.R.
The Editor-in-chief

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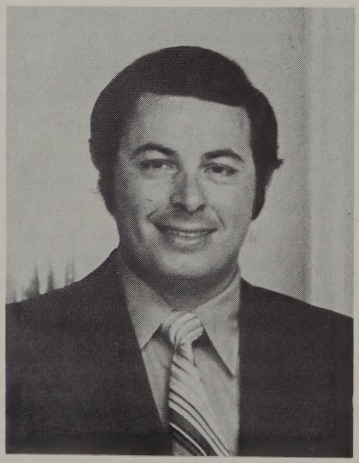

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Seeks AMA presidency

Dr. Ballantine

H. Thomas Ballantine Jr., MD, Boston, has announced his candidacy for president-elect of the American Medical Association in 1976-77.

Dr. Ballantine, 63, is a neurosurgeon in private practice, and has held many medical leadership positions. An AMA delegate, he heads the Ad Hoc Committee on Internal Affairs that has assisted in meeting the Association's recent financial crisis.

HE IS THE SECOND announced candidate for president-elect. The other is John H. Budd, MD, of Cleveland, a member of the Board of Trustees *(AMN,* Oct. 13).

Dr. Ballantine is a past president of the Massachusetts Medical Society, and serves as chairman of its judicial committee and committee on public relations. He is a member of the Board of Registration in Medicine, and is a director of Blue Shield of Massachusetts.

He has been a governor of the American College of Surgeons and an officer of several neurosurgical societies. He is president of the Commonwealth Institute of Medicine.

BORN IN MUSKOGEE, Okla., the son of a general practitioner, Dr. Ballantine received his MD degree from Johns Hopkins U. Medical School, after receiving BS degree from Princeton U. He received postgraduate training in surgery and neurosurgery at Massachusetts General Hospital.

Dr. Ballantine was board certified in surgery in 1946, in neurosurgery in 1949.

During World War II, he served in the Army Medical Corps in the combat zones of North Africa, Sicily, and Italy, and was discharged as a lieutenant colonel.

He has been a member of the neurosurgical staff of Massachusetts General Hospital, and an associate clinical professor of surgery at Harvard Medical School.

Reprinted from AMA News
October 20, 1975

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Poet's Corner

Thanksgiving 1975

Once again the eleventh month, and its fourth Thursday are here,
The year's labours have borne fruit, the harvest is in.
As our Pilgrim and Puritan forefathers did—so must we,
Give thanks to the Almighty for His love and bounty.

Where else on this Earth is a country so bountifully blessed?
300 years ago, we starved on a continent's edge;
Today, we control the World with our ideas and products.
200 years ago, we declared ourselves a new nation;
Today, we control half of the World's wealth and inspired others.
100 years ago, we remade our declared vows in blood;
Today, we still struggle to have a perfect union, all persons equal.

Where else on the Earth is the revolution still in evolution?
With all our problems of family, finances and face,
Where else is there a better land in which to raise your family?
With all our human foibles, follies and flukes,
Where else is there a chance to freely change and to grow?
With all our inconsistencies, reversals and sidetracks,
Where else is found the spirit of "The truth shall make you free?"

Truly, it may be God's plan, for Heaven and its goals
To be established here on Earth, by human effort.
His proving ground lies within us, within our souls.

for Thanksgiving day 1975
The Editor-in-chief

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Happiness

Have you ever pondered to consider for a moment
that throughout our life—whatever its season
We are always running toward something
Or constantly running away from something.

In our early youth—days are long and life, an infinity,
In our middle years—the inevitable struggle to climb upward;
To hold and maintain our firmament and family
In togetherness, as one by one, they are transplanted.

We often fail to live each day to its fullest
Come what may—to see the beauty of nature
The towering trees, the vast sky and the endless sea
And to see the best in man and to touch his hand to help.

And as the days grow shorter and the nights longer
We begin to reflect in the autumn of our life
Our deeds and misdeeds; the pluses and minuses in the years of strife.
Whence we came, what have we learned, when is the journey's end?

Happy is the man who has learned from his mistakes
Happy is the man who has loved and in turn has been loved
Happy is the man who has known a friend and the love of a child
But happier is the man who has given of himself more than his possessions.

S. A. Zacarian, M.D.
10/1/75

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Poet's Corner (Cont.)

God did not create hate, nor envy in man,
poor puny man did this to himself,
In his ignorance of his innate divine
gift from the creator.

Although banished children we are,
from his golden orchard
of apples on the tree, and
sparkling eyed serpent there entwined.

Sent down to this sphere of revolving earth,
cast out from paradise,
endlessly revolving round
a diminishing yellow sun,

cast down,
out,
because of our horrendous appalling fate,
destined by the sweat of brow,
the toil of hands,
to pluck from the brownd earth
seeds and leaven for his bread.

Birth,
work,
death.

A travail of tears.
Loss of limb, diminishing senses,
willowing from within.

And, oh yes,
Sin.

John Francis Speight

Reprinted from Newsletter
Mass. Med. Society—Sept. 1975

Reprinted from AMA News
Oct. 20, 1975

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NUGGETS
from Insurance Files

Epigastric distress in right lower quadrant of abdomen.

Diagnosis: I thought he was just plain tired.

The applicant was recently married, having married a woman with four small children by a previous mortgage.

Diffused non toxic garter.

He is single having never married. He lives with her parents.

Culligen's Disease.

Has varicose veins of the left leg that won't go away.

Operation on son: Lowering of his testicles.

No erythema. No dosum.

The diagnosis of spasm of the coronary artery was basically made because the hospital required that a diagnosis be recorded on the chart.

He does not fly nor engage in any hazardous sports. He is a New York taxi driver.

Nuggets (cont.)

Dislocated vertebra in Lower Lombard.

Anemic dysentery.

Dr. B. says he has never had hemorrhoids and is perfectly willing for you to examine his ano if you wish him to prove it to you.

The house is not kept neat and clean at all times but is stated to be generally clean and well kept. Sources would not state definitely that it is not kept clean at all times.

Lymphodema of unknown ideology.

He is employed as a physician and surgeon. He has a lady receptionist under him, no one else.

Applicant was hospitalized a few years ago to remove dust particles on his brain which was said to be done by blowing air through his spine.

The above has a congenial heart.

Operation of coordination of aorta.

Kneck of bladder reamed.

Injury to lumber of back.

Has a "turbinate" of the nose.

Pregnancy expected in later part of this year.

Operation: Scrapping of uterus.

A history of immediate dysentery.

Since he has started school he has stayed with his class, which would indicate mental abnormality.

He was D.O.A. on arrival.

Had serious lung condition: Xanthal asthma.

Pollocks taken from nose. Paronoid cyst removed from spine.

Planetary wart.

Pabst smear.

Had kidney stone . . . went to hospital and got shot and next morning at home he passed the stone.

Usually I grasp a little after eating for breath because of a cold in my throat.

His prior history was unremarkable except for premature death due to heart disease in his family.

Ulcer on ankle from burn received when he fell off a motorcycle which was infected.

Fraternal grandmother had diabetes.

He was a barber and found his work somewhat anxiety producing.

Howard N. Simpson

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DRUG UTILIZATION AND THE MEDICAID PROGRAM

Since November 1, 1973, Pilgrim Health Applications has been administering the Medicaid Drug Program for the Commonwealth of Massachusetts. Drug Utilization Review has been an integral part of Pilgrim Health Applications responsibilities.

PHI has been advising physicians on drug utilization by their patients with a "Dear Doctor" letter. The letter is intended to share with you information about the activity of a patient you have treated and/or prescribed for. The letter is recommended to be sent by one of eight Drug Utilization Review Committee's each consisting of four pharmacists and one physician. These committee members meet each month and review recipient profiles, which display drug purchases made with their welfare cards.

The profiles are generated by the computer on what is called an exception basis. This simply means that predetermined programmed limitations have been exceeded. The profiles are discussed with the physician and other pharmacists at the meeting. There are four types of letters that could be sent, they are: 1) in reference to small quantities prescribed and/or dispensed, 2) in reference to shopping different physicians and/or pharmacies, 3) in reference to apparent over utilization of medicines, and 4) in reference to repeated renewals.

When, and if you receive one of these letters, it is intended to inform you of your patients activity and utilization of pharmaceutical and medical services. There may be no problem at all as far as you are involved on the profile, but one may develop when other services are combined with yours. This activity up to this point, was without your knowledge and out of your control.

Now when all facts are considered concerning the patients activity, a different course may be taken by you when visited by this patient in the future.

It is our hope that these letters are read with interest and concern. Your response to them is most valuable. A self-addressed postage paid envelope is enclosed with each of these profiles for your response. If you have any questions, just write it on the response and you will be contacted.

The desired result from these interprofessional communications is to promote better health care delivery by limitation of the abuse of medications and the "System" by participants in the Medicaid Program. By achieving these ends, a substantial savings of tax dollars is realized.

James H. Stewart, R.Ph., *Director of Professional Relations*, Pilgrim Health Applications, 41 North Road, Bedford, MA 01730.

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WELFARE PATIENTS AND DRUGS

The Medical Assistance Division is now taking steps to insure compliance by providers (physician/pharmacist) with Regulation #3 of the *Rules and Regulations for Pharmacy Program under Medical Assistance.*

"3. Telephone prescriptions will be allowed but no pharmacy may bill the Medical Assistance Program unless there is a signed prescription on file in the pharmacy."

Recent pharmacy audits have shown "irrational" *prescribing/dispensing* patterns which were caused by excessive telephone prescribing without a follow-up prescription by the physician. In some cases there was no physician authorization for the dispensed medication.

Pharmacist compliance with Reg. 3 will mean that unless the pharmacist receives an original signed prescription from the physician, the pharmacist will not be allowed to bill the Department for a prescription that was dispensed on a telephone order.

It is now the practice of the pharmacist to reduce all telephone orders to a written prescription and obtain the physician's signature at a later date. This *does not* represent the physician's original signed prescription and will not be an acceptable procedure to the Department.

The physician will now be responsible for the preparation, signing and delivery of the prescription to the pharmacy after any telephone order.

Considering the dramatic growth of the Medicaid Pharmacy (over 30 million dollars in the Commonwealth) and the existing laws, (Controlled Substances Act — Chpt. 94C, Mass. G.L.) combined with our State's fiscal crises, I believe that the physicians of Massachusetts will comply with Regulation 3.

The Medicaid Pharmacy Program is for the medically needy only, and any use of drugs for "recreational" or non-medical purposes must be eliminated from the program.

I believe that physician cooperation will bring our pharmacy program back into perspective and save taxpayer dollars as well as improving drug utilization.

George Levey
Director
Mass. Medicaid Pharmacy Program

Reprint from MMS Newsletter

DISTRICT MEETING

Tuesday, November 25, 1975

BUSINESS MEETING
6:00 P.M.

Speakers
George D. LeMaitre, M.D.
New England Regional Director
Council of Medical Staffs

Mr. Michael Meyrick
Representative
Drug Enforcement Agency

SOCIAL HOUR
7:00 P.M.

DINNER
7:30 P.M.

COST
$8.00

PLACE
Yankee Pedlar
Holyoke, Massachusetts

SPEAKER
Mr. Robert Woolrich
Review Coordinator
Western Massachusetts Health Planning
Council

TOPIC
Public Law 93-641

If you must cancel your dinner reservation, please call the office before noon on November 25, 1975.

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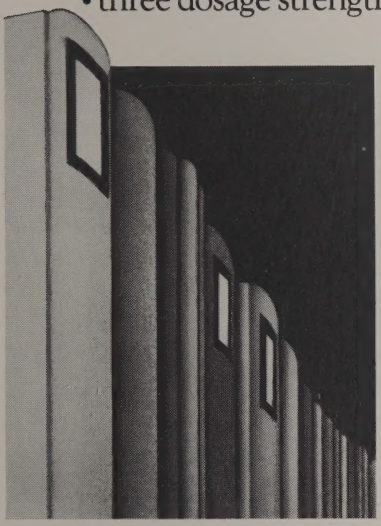

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.
Contraindications: Patients with known hypersensitivity to the drug.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.
Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients, and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.
Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.
Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)
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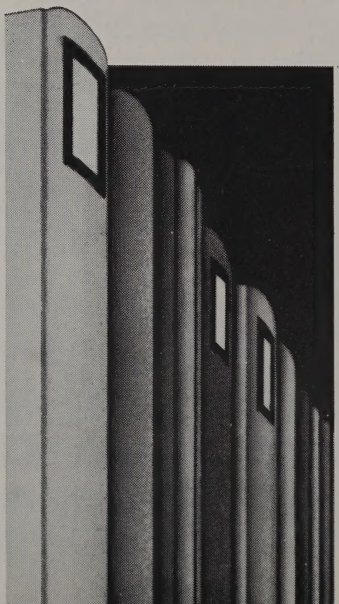

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